The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Professions Licensure
Drug Control Program
250 Washington Street, 3rd floor
Boston, MA 02114

Tel: 617-973-0949
TTY : 617-973-0988
www.mass.gov/orgs/massachusetts-controlled-substances-registration

Massachusetts Controlled Substance Registration (MCSR)
Advanced Practice Provider and Supervising Physician Removal Form

Instructions

Please read the following information carefully before completing the form**:**

1. **Items with an asterisk are mandatory. We are unable to process incomplete forms.**
2. **Supervising Physicians: If you are removing more than six advanced practice providers, please photocopy page 2 and include that with your form submission.**
3. **Attest to the content of the form by signing and dating. The Drug Control Program cannot accept amended information forms without a signature.**
4. **When complete, send the amended information form by either email, fax, or mail:**

Email: MCSR@massmail.state.ma.us
Fax: 617-753-8233
Mail:
Bureau of Health Professions Licensure
Drug Control Program, Attn: MCSR
250 Washington Street, 3rd Floor
Boston, MA 02108

Carefully Print or Type the Following Information:

To be completed by Supervising Physician

First Name*:	**Last Name*:**	**MCSR Number*:**	**Massachusetts Medical License Number*:**

☐ **Remove an Advanced Practice Provider (NP/PA/CDTM RPh)**		
Last Name*:	**First Name*:**	**MCSR #*:**

☐ **Remove an Advanced Practice Provider (NP/PA/CDTM RPh)**		
Last Name*:	**First Name*:**	**MCSR #*:**

☐ **Remove an Advanced Practice Provider (NP/PA/CDTM RPh)**		
Last Name*:	**First Name*:**	**MCSR #*:**

☐ **Remove an Advanced Practice Provider (NP/PA/CDTM RPh)**		
Last Name*:	**First Name*:**	**MCSR #*:**

☐ **Remove an Advanced Practice Provider (NP/PA/CDTM RPh)**		
Last Name*:	**First Name*:**	**MCSR #*:**

☐ **Remove an Advanced Practice Provider (NP/PA/CDTM RPh)**		
Last Name*:	**First Name*:**	**MCSR #*:**

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form, and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this form is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties. My signature on this MCSR form attests under penalties of perjury that, to the best of my knowledge and belief, I have complied with laws of the Commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Drug Control Program.

Signature*: ____

Date*: ____________________

To be completed by Advanced Practice Provider (PA, APRN, CDTM RPh)			
First Name*:	**Last Name*:**	**MCSR Number*:** *Initial applicants indicate "Pending"*	**Board of Registration License Number*:**

Remove a Supervising Physician *Complete this section if removing a Supervising Physician from your MCSR.*		
Supervising Physician First Name*:	**Supervising Physician Last Name*:**	**Supervising Physician MCSR Number*:** *To verifiy an MCSR # visit:* https://madph.mylicense.com/verification/
Supervising Physician First Name*:	**Supervising Physician Last Name*:**	**Supervising Physician MCSR Number*:** *To verifiy an MCSR # visit:* https://madph.mylicense.com/verification/
Supervising Physician First Name*:	**Supervising Physician Last Name*:**	**Supervising Physician MCSR Number*:** *To verifiy an MCSR # visit:* https://madph.mylicense.com/verification/
Supervising Physician First Name*:	**Supervising Physician Last Name*:**	**Supervising Physician MCSR Number*:** *To verifiy an MCSR # visit:* https://madph.mylicense.com/verification/

I hereby certify that, under pains and penalties of perjury, all of the information submitted in this form, and attachments is true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this form is grounds for MCSR revocation or denial of the MCSR and may subject me to civil or criminal penalties. My signature on this MCSR form attests under penalties of perjury that, to the best of my knowledge and belief, I have complied with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations of the Department of Public Health and the Drug Control Program.

Signature*: ____

Date*: ____________________